KAMALA D. HARRIS
Attorney General of California
ARTHUR D. TAGGART
Supervising Deputy Attorney General
KAREN R. DENVIR
Deputy Attorney General
State Bar No. 197268
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5333
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JOHN JOSE LIZARRAGA** **41149 Adobe Way** **Madera, California 93636** **Registered Nurse License No. 556525** Respondent.	Case No. 2011-886 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about July 9, 1999, the Board issued Registered Nurse License Number 556525 to John Jose Lizarraga ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2013, unless renewed.

JURISDICTION

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

5. Code section 2761(a) states, in pertinent part, that the board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

8. "Phenobarbital" is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(26).

9. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M).

10. "Ativan" a brand of lorazepam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(13).

11. "Percocet" a brand of oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(N).

12. "Citalopram" is a generic name for Celexa, a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d).

FIRST CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)

13. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(e), in that while employed as a registered nurse at Community Regional Medical Center, located in Fresno, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

Patient D:

a. On or about March 20, 2008, at 1452 hours, Respondent signed out two (2) 4 mg. injectables of Morphine. Respondent charted administering 8 mg. of Morphine to the patient at 1450 hours. The administration of the Morphine was inconsistent with physician's orders which called for the administration of 4-6 mg. of Morphine.

b. On or about March 20, 2008, at 1659 hours, Respondent signed out two (2) 4 mg. injectables of Morphine. Respondent charted administering 8 mg. of Morphine to the patient at 1730 hours, which is inconsistent with physician's orders that called for the administration of 4-6 mg. of Morphine.

Patient E:

c. On or about March 10, 2008, at 0950 hours, Respondent signed out two (2) 4 mg. injectables of Morphine. Respondent charted administering 4 mg. of Morphine to the patient at 1000 hours, but failed to account for the disposition of the remaining 4 mg. of Morphine in any hospital or patient record.

d. On or about March 10, 2008, at 1017 hours, Respondent signed out two (2) 4 mg. injectables of Morphine. Respondent charted administering 6 mg. of Morphine to the patient at 1030 hours, but failed to account for the disposition of the remaining 2 mg. of Morphine in any hospital or patient record.

e. On or about March 10, 2008, at 1036 hours, Respondent signed out one (1) 2 mg. injectable of Ativan. Respondent charted administering 1 mg. of Ativan to the patient, but failed to account for the disposition of the remaining 1 mg. of Ativan in any hospital or patient record.

f. On or about March 10, 2008, at 1231 hours, Respondent signed out two (2) 4 mg. injectables of Morphine. Respondent charted administering 6 mg. of Morphine to the patient at 1130 hours, which is 61 minutes prior to withdrawing the Morphine. In addition, Respondent failed to account for the disposition of the remaining 2 mg. of Morphine in any hospital or patient record.

g. On or about March 10, 2008, at 1553 hours, Respondent signed out one (1) 2 mg. injectable, and one (1) 4 mg. injectable of Morphine. Respondent charted administering 6 mg. of Morphine to the patient at 1730 hours, which is 1 hour and 37 minutes after withdrawing the medication.

Patient F:

h. On or about March 14, 2008, at 0822 hours, Respondent signed out one (1) 4 mg. injectable of Morphine. Respondent charted administering Morphine to the patient at 0815 hours, which is seven (7) minutes before withdrawing the medication, and failed to document the amount of Morphine administered.

i. On or about March 14, 2008, at 1043 hours, Respondent signed out one (1) 4 mg. injectable of Morphine. Respondent charted administering Morphine to the patient at 1000 hours, which is forty-three (43) minutes before withdrawing the medication, and failed to document the amount of Morphine administered.

j. On or about March 14, 2008, at 1227 hours, Respondent signed out one (1) 4 mg. injectable of Morphine. Respondent charted administering Morphine to the patient at 1230 hours, but failed to document the amount of Morphine administered.

k. On or about March 14, 2008, at 1429 hours, Respondent signed out one (1) 4 mg. injectable of Morphine. Respondent charted administering Morphine to the patient at 1430 hours, but failed to document the amount of Morphine administered.

l. On or about March 14, 2008, at 1808 hours, Respondent signed out two (2) 4 mg. injectables of Morphine. Respondent charted administering Morphine to the patient at 1830 hours, but failed to document the amount of Morphine administered.

Patient G:

m. On or about March 19, 2008, at 1110 hours, Respondent signed out one (1) 10 mg. injectable of Morphine. Respondent charted administering 10 mg. of Morphine to the patient, which is inconsistent with physician's orders that called for the administration of 6 mg. of Morphine.

n. On or about March 19, 2008, at 1123 and 1332 hours, Respondent signed out one (1) 2 mg. injectable of Ativan on each occasion without a physician's order. Respondent wasted 2 mg. of Ativan at 1511 hours, which is over an hour after withdrawing the medication. In addition, Respondent failed to account for the disposition of the remaining 2 mg. of Ativan in any hospital or patient record.

o. On or about March 19, 2008, at 1326 hours, Respondent signed out one (1) 10 mg. injectable of Morphine. Respondent charted administering 6 mg. of Morphine to the patient at 1330 hours, but failed to account for the disposition of the remaining 4 mg. of Morphine in any hospital or patient record.

p. On or about March 19, 2008, at 1625 hours, Respondent signed out two (2) 4 mg. injectables of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient record.

Patient H:

q. On or about April 7, 2008, at 1742 hours, Respondent signed out two (2) 4 mg. injectables of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient record.

r. On or about April 7, 2008, at 1916 hours, Respondent signed out two (2) 4 mg. injectables of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient record.

SECOND CAUSE FOR DISCIPLINE

(Possessed and Self-Administered Controlled Substances)

14. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(a), in that while a registered nurse, Respondent did the following:

August 29, 2008

a. On or about August 29, 2008, while working with Nurse Finders (registry) located in Fresno, California, Respondent tested positive for Phenobarbital during an employment drug screen.

i. Respondent possessed Phenobarbital, a controlled substance, in violation of Code section 4060, in that he did not have a prescription for that controlled substance.

ii. Respondent self-administered Phenobarbital, a controlled substance, without direction to do so from a licensed physician and surgeon, dentist or podiatrist.

June 21, 2010

b. On or about June 21, 2010, during an interview with a Board investigator, Respondent submitted a urine sample that tested positive for Citalopram.

i. Respondent possessed Citalopram, a controlled substance, in violation of Code section 4060, in that he did not have a prescription for that controlled substance.

ii. Respondent self-administered Citalopram, a controlled substance, without the direction to do so from a licensed physician and surgeon, dentist or podiatrist.

///

///

///

///

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 556525, issued to John Jose Lizarraga;

2. Ordering John Jose Lizarraga to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/27/11

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2010102482